Adopt Ins 3900, to read as follows:

**CHAPTER Ins 3900 DISABILITY INSURANCE**

Statutory Authority: RSA 400-A:15; RSA 415-A:6

PART Ins 3901.01 Disability Insurance

**Ins 3901.01 Purpose.** In accordance with RSA 415-A and the U.S. Department of Labor Benefit Claims Procedure Regulation, 29 CFR 2560.503, as existing and thereafter amended, this section establishes the minimum requirements for carriers pertaining to claims for disability benefits by participants and claimants. Except as otherwise specifically provided in this section, these requirements apply to every group policy provided by the carrier that contains disability benefits.

**Ins 3901.02 Definitions.** The following terms mean as follows whenever such term is used in this section:

(a) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or claimant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(b) "Health care professional" means a physician or other health care provider that is licensed, accredited, or certified to perform specified health services consistent with state law.

(c) "Relevant to a claimant's claim" means that a document, record or other information was relied upon in making the benefit determination or was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; or the documents or information demonstrate compliance with the administrative processes and safeguards required pursuant to in making the benefit determination; or that the documents or information constitute a statement of policy or guidance with respect to the carrier's policy concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**Ins 3901.03 Claims Procedures.**

(a) Health carriers that offer disability benefits shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures shall be deemed to be reasonable only if:

(1) They contain a description of all procedures, including, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures and the applicable time frames as part of a summary plan description; and

(2) They do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. A provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits, as would the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant would constitute a practice that unduly inhibits the initiation and processing of a claim; and

(3) They do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant; and

(4) They contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing documents and that, where appropriate, the provisions in the policy have been applied consistently with respect to similarly situated claimants.

(b) Appeal of benefit determinations. The claims procedures of group disability coverage for appealing benefits determination shall be deemed to be reasonable only if:

(1) They do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action; and

(2) To the extent that a carrier offers voluntary levels of appeal, including voluntary arbitration or any other form of dispute resolution, the procedures provide that:

a. The carrier waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the carrier; and

b. The carrier agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending; and

c. The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by this rule; and

d. The carrier provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(3) No fees or costs shall be imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

a. The arbitration is conducted as one of the two appeals described in paragraph and in accordance with the requirements applicable to such appeals; and

b. The claimant is not precluded from challenging the decision under other applicable law.

(c) Filing benefit claims. The claims procedures of a group disability coverage for filing benefit claims shall be deemed reasonable only if:

(1) For disability benefit claim determinations, the carrier's procedures require it to notify the claimant of the carrier's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the carrier both determines that such an extension is necessary due to matters beyond its control and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the

extension of time and the date by which the carrier expects to render a decision. If, prior to the end of the first 30-day extension period, the carrier determines that, due to matters beyond the control of the carrier, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the carrier notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the carrier expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(2) In calculating time periods for benefit determinations, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a carrier, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(d) Notification of benefit determinations. The carrier shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination; and

(2) Reference to the specific policy provisions on which the determination is based; and

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) A description of the carrier's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.

(e) Content of benefit determination. The notification of a benefit determination shall contain the following information:

(1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the carrier shall agree to provide either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination, guideline, protocol, or other criterion will be provided.

(2) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the carrier shall agree to provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances; or a statement that such explanation will be provided free of charge upon request.

(f) Appeal of adverse benefit determinations. Every carrier that offers group disability insurance shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the carrier, and under which there will be a full and fair review of the claim and the adverse benefit determination. The claims procedures of a group disability policy will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures:

(1) Provide a claimant with at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination; and

(2) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the carrier who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and

(3) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; and

(4) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the carrier in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(5) Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(g) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(h) Timing of notification of benefit determination on review.

(1) The carrier shall notify a claimant of its benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant's request for review by the carrier, unless the carrier determines that special circumstances (such as the need to hold a hearing, if the carrier's procedures provide for a hearing) require an extension of time for processing the claim. If the carrier determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the carrier expects to render the determination on review.

(2) Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of the carrier, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(i) Manner and content of notification of benefit determination on review. The carrier shall provide a claimant with written or electronic notification of a its benefit determination on review. In the case of benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination; and

(2) Reference to the specific policy provisions on which the benefit determination is based; and

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring a legal action.

(j) The carrier shall provide such access to, and copies of, documents, records, and other information as is required by the claimant to appeal.

(k) Manner and content of notification of adverse benefit determination. The carrier shall meet the following requirements in making and notifying the claimant of an adverse benefit determination:

(1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the carrier shall provide the claimant with either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and shall agree to provide a copy of the rule, guideline, protocol, or other similar criterion free of charge to the claimant upon request; and

(2) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the carrier shall provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(3) The carrier shall include in the notice of adverse benefit determination the statement "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your State insurance regulatory agency."

**Ins 3901.04 Failure to establish and follow reasonable claims procedures.**

(a) In the case of the failure of a carrier to establish or follow its claims and appeals procedures, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available legal remedies on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

**Ins 3901.05 Effective Date.** This section shall apply to claims filed under a plan on or after January 1, 2004.

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